TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
GRAPEVINE SURGICARE PARTNERS

Respondent Name
VALLEY FORGE INSURANCE CO

MFDR Tracking Number
M4-17-2213-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
MARCH 21, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "At this time we are requesting that this claim paid in accordance with the 2016 Texas Workers Compensation Fee Schedule and Guidelines."

Requestor's Supplemental Position Summary: "I got a settlement offer on 04/13/17 but I declined it. Other than that I haven't gotten anything.

Amount in Dispute: $19,349.23

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "At this time, Carrier maintains any and all denials as represented in the EORs."

Response Submitted by: Law Office of Brian J. Judis

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 22, 2016	Ambulatory Surgical Care Services for Knee Surgery CPT Code 29889-59-LT	$5,057.44	Overpayment of $6,372.18
	Ambulatory Surgical Care Services for Knee Surgery CPT Code 29889-59-LT	$9,103.33	Overpayment of $3,186.09
	Ambulatory Surgical Care Services for Knee Surgery CPT Code 27427-LT	$995.20	$30.52
	Ambulatory Surgical Care Services for Knee Surgery CPT Code 29881-LT	$536.22	$16.44

	Ambulatory Surgical Care Services for Knee Surgery CPT Code 29882-59-LT	$535.73	$16.44
	HCPCS Code L8699	$8,956.83	$5,123.29
TOTAL		$19,349.23	Overpayment of $9,558.27 minus amount due of $5,186.69 = $0.00 additional reimbursement

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §133.10 sets out the general medical billing procedures.
3. 28 Texas Administrative Code §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

    - P12-Workers compensation jurisdictional fee schedule adjustment.
    - P300-The amount paid reflects a fee schedule reduction.
    - Z710-The charge for this procedure exceeds the fee schedule allowance.
    - XV34-We have received invoices on apportion of the implantable items billed, please submit invoices for the remaining items.
    - W3-Request for reconsideration.
    - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

Is the requestor entitled to additional reimbursement for ambulatory surgical care services rendered on September 22, 2016?

Findings

1. The requestor is seeking additional reimbursement of $19,349.23 for ambulatory surgical care services , CPT codes 29889-59-LT (X2), 27427-LT, 29881-LT, 29882-59-LT and L8699, rendered to the claimant on September 22, 2016.
2. A review of the submitted medical bill indicates in Box #19, "Device + 10% + 235% service expected."

    28 Texas Administrative Code §133.10(f)(1)(W) states, "All information submitted on required paper billing forms must be legible and completed in accordance with this section. The parenthetical information following each term in this section refers to the applicable paper medical billing form and the field number corresponding to the medical billing form. (1) The following data content or data elements are required for a complete professional or noninstitutional medical bill related to Texas workers' compensation health care: (w) supplemental information (shaded portion of CMS-1500/fields 24d - 24h) is required when the provider is

requesting separate reimbursement for surgically implanted devices or when additional information is necessary to adjudicate payment for the related service line."

Because the requestor requested separate reimbursement in box # 19 instead of # 24, the division finds the requestor did not complete the bill in accordance with 28 Texas Administrative Code §134.402(f)(1)(W). The division further finds that the respondent processed the bill honoring the request for separate reimbursement for the implantables.

3. The fee guideline for Ambulatory Surgical Care services is found in 28 Texas Administrative Code §134.402.

   28 Texas Administrative Code §134.402(d) states,

   > For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section.

   The definitions for the codes billed are:

   - CPT code 29889 is defined as "Arthroscopically aided posterior cruciate ligament repair/augmentation or reconstruction." CPT code 29889 is classified as a device intensive procedure.
   - CPT code 27427 is defined as "Ligamentous reconstruction (augmentation), knee; extra-articular." CPT code 27427 is classified as a non-device intensive procedure.
   - CPT code 29881 is defined as "Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed." CPT code 29881 is classified as a non-device intensive procedure.
   - CPT code 29882 is defined as "Arthroscopy, knee, surgical; with meniscus repair (medial OR lateral)." CPT code 29882 is classified as a non-device intensive procedure.
   - HCPCS code L8699 is defined as "Prosthetic implant, not otherwise specified."

4. To determine if the requestor is due additional reimbursement for code 29889-59-LT X2, the division refers to 28 Texas Administrative Code §134.402(f)(2) which states, "Reimbursement for device intensive procedures shall be: (A) the sum of: (i) the ASC device portion; and (ii) the ASC service portion multiplied by 235 percent; or (B) If an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the device intensive procedure shall be the sum of: (i) the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission; and (ii) the ASC service portion multiplied by 235 percent."

   To determine the service portion for code 29889 is a four-step process:

   Step 1-Gather factors:

   - According to Addendum B found on CMS website, the hospital outpatient prospective payment amount for 29889 is $10,537.90.
   - The device dependent APC offset percentage found in Table 66 for National Hospital OPPS for code 29889 for CY 2016 is 53.97%.
   - According to Addendum AA found on CMS website, CPT code 29889 has a Medicare ASC reimbursement of $7,886.65.
   - The Core Based Statistical Area (CBSA-City Wage Index) located on the White House/OMB website or CMS website for Grapevine, Texas is 0.9847.

   Step 2- To determine the device portion, you multiply the hospital outpatient prospective payment amount times the device dependent APC offset percentage:

   $10,537.90 multiplied by 53.97% = $5,687.30.

Step 3 - Find the geographically adjusted Medicare ASC reimbursement for code 29889. This step requires calculations:

- The Medicare fully implemented ASC reimbursement rate of $7,886.65 is divided by 2 = $3,943.33.
- This number multiplied by the City Wage Index for Grapevine, TX $3,943.33 X 0.9847 = $3,883.00.
- The sum of these two is the geographically adjusted Medicare ASC reimbursement $3,943.33+ $3,883.00= $7,826.33.

Step 4- To determine the service portion:

- Subtract the device portion from the geographically adjusted Medicare ASC reimbursement $7,826.33 minus $10,537.90 = -$2,711.57.
- Multiply the service portion by the DWC payment adjustment factor of 235% -$2,711.57 multiplied by 235% = -$6,372.19.

On the disputed date, the requestor billed for two units of code 29889. The second unit is subject to multiple procedure rule discounting; therefore, -$6,372.19 X 50% = -$3,189.09.

5. To determine the MAR for code 27427 a non-device intensive procedure, the division refers to 28 Texas Administrative Code §134.402(f)(1)(A) which states,

> The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the Federal Register. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the Federal Register, or its successor. The following minimal modifications apply:
> (1) Reimbursement for non-device intensive procedures shall be:
> (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent; or
> (B) if an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the non-device intensive procedure shall be the sum of:
> (i) the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission; and
> (ii) the Medicare ASC facility reimbursement amount multiplied by 153 percent.

The Medicare ASC reimbursement rate for code 27427 CY 2016 is $2,486.22.

The City wage index for Grapevine, Texas is 0.9847.

To determine the geographically adjusted Medicare ASC reimbursement for non-device intensive procedures use the following formula:

- The Medicare ASC reimbursement rate of $2,486.22 is divided by 2 = $1,243.11.
- This number multiplied by the City Wage Index $1,243.11 X 0.9847 = $1,224.09.
- Add these two together = $2,467.20.

To determine the MAR multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 153%.

$2,467.20 X 153% = $3,774.81. Per Addendum AA, this code is subject to multiple procedure rule discounting; therefore, $3,774.81 X 50% = $1,887.40. The respondent paid $1,856.88. The difference between MAR and amount paid is $30.52, this amount is recommended.

6. To determine the MAR for code 29881-LT a non-device intensive procedure, the division refers to 28 Texas Administrative Code §134.402(f)(1)(A) and the formula listed above (#3).

   The Medicare ASC reimbursement rate for code 29881-LT CY 2016 is $1,339.58. This code is also subject to multiple procedure rule discounting.

   Using the above formula the division finds the MAR is $1,016.93. The respondent paid $1,000.49. The difference between MAR and amount paid is $16.44, this amount is recommended for additional reimbursement.

7. To determine the MAR for code 29882-LT a non-device intensive procedure, the division refers to 28 Texas Administrative Code §134.402(f)(1)(A) and the formula listed above (#3).

   The Medicare ASC reimbursement rate for code 29882-LT CY 2016 is $1,339.58. This code is also subject to multiple procedure rule discounting.

   Using the above formula the division finds the MAR is $1,016.93. The respondent paid $1,000.49. The difference between MAR and amount paid is $16.44, this amount is recommended for additional reimbursement.

8. 28 Texas Administrative Code §134.402(b)(5) states "Implantable" means an object or device that is surgically:
   (A) implanted,
   (B) embedded,
   (C) inserted,
   (D) or otherwise applied, and
   (E) related equipment necessary to operate, program, and recharge the implantable."

   The requestor billed HCPCS code L8699 for the implants, to determine if additional reimbursement is due, the division refers to 28 Texas Administrative Code §134.402(f)(2)(B)(i).

   28 Texas Administrative Code §134.402(f)(2)(B)(i) states, "The reimbursement calculation used for establishing the MAR shall be…(B) if an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the device intensive procedure shall be the sum of: (i) the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission."

   The Division reviewed the invoices and finds the MAR for the implantables is:

Invoice	Unit Cost	10% not to exceed $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 per admission	MAR (Cost + 10%)
Musculoskeletal Transplant Foundation	$1,688.00	$168.80	$1,856.80
Arthrex	$2,501.50	$250.15	$2,751.65
Biomet	$2,846.47	$284.64	$3,131.11
TOTAL	$7,035.97	$703.59	$7,739.56

The Division finds the total allowable for the implantables is $7,739.56. The respondent paid $2,616.27. The difference is $5,123.29.

Based upon the difference between MAR and overpayment, the requestor is not due additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		6/27/2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.